**EXHIBIT C**

**If your review goes over the amount of time assigned by RRS please call for approval.**

Date:

To: Diane Baumbach
Hartford - Maitland

Re: Case # 14119

Employee: Josephine Testa
Claim #: [redacted]
Disability Type: LTD
☒ Initial claim ☐ Re-review ☐ Appeal

**Advisory Report #1 – Lead reviewer- Dr. Mosbach**

**Clinical History:**

**Documents Sent for Review and Attending Provider Contact if Indicated:**

| Document Date or ph. call, date and time | Type of Document or Person you spoke with: | Document Prepared by: |
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**Discussion with Attending Provider:**

**Questions and Reviewer's Response:**

**Assessment/Rationale:**

**Reviewer Time: _____ Minutes**

**If your review goes over the amount of time assigned by RRS please call for approval.**

**Advisory Report #2 – Second reviewer- Dr. Farber**

**Clinical History:**

**This case took an additional 80 minutes to complete.**

She is a 48-year-old payroll supervisor, who according to limited documentation provided for review, has a history of complicated migraine headaches (1985), anxiety/depression, cervical neck and lumbar radiculopathy, left shoulder rotator cuff tendinosis/impingement (2004), and knee discomfort s/p unclear invasive intervention (1995, 1996).

History is significant for migraine headaches (1985) complicated in 2004 by increased frequency and duration and development additional symptoms (visual aura, photophobia, nausea, vomiting, sleep disruption, concentration and memory impairment, etc). Furthermore, throughout the years she had various subjective complaints (tenderness to neck, low back, knees, and shoulder) and physical examination findings (tenderness with limited ROM, decreased grip, and non-specific decreased pinprick sensation) suggestive of arthritic cervical and lumbar disease complicated by radiculopathy. She has been under care of various specialists (neurologist, chiropractic) with extensive diagnostic testing including MRI (08/10/2004) and MRA (09/28/2006) of brain that revealed a tiny foci of hyperintensity in the subcortical white matter and left lentiform nucleus that was of unknown and questionable significance and no evidence of vasculitis respectively. Cervical MRI (08/20/2004) and NCV/EMG studies (08/17/2004) revealed mild central canal stenosis at C5-6 and C6-7 with disc osteophytes and protrusion contributing to compression of right ventral cord and moderate to severe multilevel foraminal stenosis with specific impingement on left C6 nerve root and radiculopathy was supported by abnormal NCV/EMG studies suggestive of left C6-7 nerve root dysfunction. Left shoulder x-ray (07/31/2006) revealed calcific tendinopathy and osteoarthritic change of the AC joint. There were no knee or lumbar imaging results made available for review. Furthermore, there was no discussion of any orthopedic evaluation or clear treatment plan regarding any of the musculoskeletal diagnoses. Notes suggest that headaches and musculoskeletal complaints were incompletely controlled despite reported participation in PT (no documentation provided) and many adjustments to medications (pain relievers, antiinflammatory, muscle relaxant, migraine specific agents, antidepressants, etc) and she was eventually referred to psychiatry (10/07/2005) for development of anxiety/depression reportedly complicated by mood swings (11/2004) and subjective inability to perform work related functions. While anxiety/depression may affect pain perception, cognition, and overall functional ability, further discussion was deferred to reviewing psychiatrist and beyond scope of my review.

**Documents Sent for Review and Attending Provider Contact if Indicated:**

| Document Date or ph.call, date and time | Type of Document or Person you spoke with: | Document Prepared by: |
|---|---|---|
| 04/14/2004 | MRI shoulder | |
| 08/10/2004 | MRI brain | |
| 2004 | Office notes | Dr. Conte |
| 2004 – 2006 | Office notes | Dr. Velazquez |
| 08/17/2004 | EMG and NCV reports | |
| 08/20/2004 | MRI cervical spine | |
| Unclear date | Physical capacities evaluation form | Dr. Velazquez |
| 10/07/2005 | Counseling evaluation | Linda Taggart, LCSW |
| 12/14/2005, 09/25/2006 | AP statement of disability | Dr. Velazquez |
| 2006 – 2007 | NCC progress notes | Linda Taggart, LCSW |
| 07/31/2006 | X-ray shoulder | |
| 09/28/2006 | MRI of brain | |
| 01/22/2007 | Letter | Linda Taggart, LCSW |
| 05/04/2007, 4:30 PM, EST | Attempted AP discussion | Dr. Velazquez |
| 05/07/2007, 9:45 AM, EST | Attempted AP discussion | Dr. Velazquez |
| 05/07/2007, 10:25 AM, EST | Co review discussion | Dr. Mosbach |
| 05/07/2007, 2:30 PM, EST | Attempted AP discussion | Dr. Velazquez |
| 05/08/2007, 9:00 AM, EST | Attempted AP discussion | Dr. Velazquez |
| 05/08/2007, 9:30 AM, EST | AP discussion | Dr. Velazquez |

**Discussion with Attending Provider:**

Several attempts were made at various times reflected in the above grid. When I spoke with staff on 05/07/2007, they assured me she would call back and when I did not get a return call I called again in the afternoon and she was gone for the day. The staff told me she would be in again at 9:00 AM on 05/08/2007 and I placed call promptly and spoke to staff. They stated that she has not arrived yet but is due in at any moment. I expressed urgency of timing to staff and that I need to speak with her as soon as she arrives for the day.

Case discussed with AP today, 05/08/2007 and after extensive discussion, she feels that musculoskeletal concerns come and go and that most limiting factor appears to be related to depression affecting headaches and ability to function. More specifically, she states that depression affects her cognition and ability to make decisions despite compliance with various therapeutic regimens. With regards to musculoskeletal diagnoses, she did not have any physical therapy or orthopedic data to provide for review.

AP: Dr. Velazquez
Specialty: Neurology
Telephone: 718-409-9100
State: NY

**Questions and Reviewer's Response:**

**Please review all information provided on claimant's physical conditions. Please contact Dr. Velazquez to discuss functionality.**

**1. Do the records support that claimant continues to be impaired from a physical condition?**

Yes.

**A. If so, what are her limitations/restrictions, and how long would they be expected to last?**

Taking all of her comorbidity into account, climbing should be completely restricted and ability to lift, push, pull, and carry weight should be limited up to about 15-20 lbs. Reaching may be limited due to left shoulder tendinopathy however specific degree and duration was difficult to determine without PT data or clear complete functional assessment examination data for review. Furthermore, frequency of standing and navigating stairs would likely be limited to occasional however once again, severity of knee and lumbar back disease could not be determined based upon limited objective data provided for review. There was no objective data to support any long-term cognitive dysfunction or inability to sit and perform most fine motor and fingering activities. Taking all of the above restrictions into account, she should be able to complete an 8-hour day of at least sedentary to light duty with above modifications. Perhaps an IME would prove useful in obtaining more specific objective functional data.

**Assessment/Rationale:**

She is a 48-year-old payroll supervisor, who according to limited documentation provided for review, has a history of migraine headaches (1985), anxiety/depression, cervical neck and lumbar radiculopathy, left shoulder rotator cuff tendinosis/impingement (2004), and knee discomfort s/p unclear invasive intervention (1995, 1996). Please refer to history section for further details.

Taking all of her comorbidity into account, climbing should be completely restricted given cervical and shoulder disease and ability to lift, push, pull, and carry weight should be limited up to about 15-20 lbs. Reaching may be limited due to left shoulder tendinopathy however specific degree of limitation and duration was difficult to determine without physical therapy data or clear complete functional assessment examination data for review. Furthermore, frequency of standing and navigating stairs would likely be limited to occasional however once again, severity of knee and lumbar back disease could not be determined based upon limited objective data provided for review. There was no objective data to support any long-term cognitive or motor dysfunction due to migraine or inability to sit and perform most fine motor and fingering activities. Taking all of the above restrictions into account, she should be able to complete an 8-hour day of at least sedentary to light duty with the above modifications. Perhaps an IME would prove useful in obtaining more specific objective functional data.

While anxiety/depression may affect pain perception, cognition, and overall functional ability, further discussion was deferred to reviewing psychiatrist and was beyond the scope of my review.

**Reviewer Time: 185 Minutes**

**Consensus Opinion: (Lead Reviewer's) – Dr. Mosbach**

All medical records provided by were reviewed. Yes Y No ☐
I attest that my completion of this review does not constitute a conflict of interest. Yes Y No ☐

Reviewer Name #1
Reviewer Name #2 Michael Farber M.D.

Date: May 08, 2007

To: Diane Baumbach
The Hartford - *Maitland*

Re: Case # 14119
Employee: Josephine Testa
Claim #: [redacted]
Disability Type: LTD
☒ Initial claim ☐ Re-review ☐ Appeal

**Advisory Report #1 – Lead reviewer – Dr. Mosbach**

**Clinical History:**

The claimant is a forty eight year old woman who last worked on 08/04/2004. The Hartford Company claim note dated 08/25/2004 stated that the claimant had a migraine headache every day which caused forgetfulness, trouble focusing on work, and caused disorientation. She also complained of nausea and vomiting. She reported needing to stay in a darkened air conditioned room.

Progress notes from neurologist, Lyzette Velazquez, M.D. were submitted. The claimant was diagnosed with migraine headaches and cervical radiculopathy. She also complained of confusion and depression. She was treated with Paxil, Elavil, Zoloft, Wellbutrin, Lexapro and Topomax. On 09/25/2006, Dr. Velazquez completed an attending physician statement. Dr. Velazquez checked that the claimant had major psychiatric impairment in several areas – work, family relations and was unable to work.

The claimant saw a psychiatrist for medication evaluation on 03/13/2006. The claimant stated she had no motivation and felt depressed. She was treated with Wellbutrin 150 mg q day. She saw the same psychiatrist on 11/26/2006. Wellbutrin was discontinued and she was started on Lexapro 10 mg q day.

A treatment plan dated 10/07/2005 from Linda Taggart, LMSW listed the claimant's diagnosis as adjustment disorder with mixed anxiety and depression. She was given a GAF of 50. The claimant was seen mostly twice a month. The claimant discussed her depression and anxiety as well as her headaches and chronic pain.

On 07/28/2006 the claimant saw Ms. Taggart. The claimant reported having panic symptoms when trying to understand or control something like a crossword puzzle. On 08/25/2006 the claimant told Ms. Taggart that she had an increase in panic symptoms which now included tunnels and enclosed places. In her 10/27/2006 session the claimant complained of poor sleep and having nightmares.

Ms. Taggart completed a statement of disability form on 11/17/2006. Ms. Taggart noted that the claimant had moderate impairment in attention, concentration and recent memory. The claimant was reported to have obsessive hand washing and excessive ruminations. Ms. Taggart stated the claimant was unable to work.

The claimant was seen for individual psychotherapy on 01/05/2007. She mentioned that she has gotten an opinion from a second neurologist and that this did not change anything. She reported doing better on Lexapro. She also discussed her mother's death.

On 01/31/2007, the claimant was seen for psychotherapy and discussed her medical condition. She was encouraged to continue with relaxation techniques. She also stated to Ms. Taggart that she had continued stress and anxiety along with continued repetitive thoughts and dreams regarding work place issues. In her 02/28/2007 session the claimant stated she was unable to stop thinking about her "trauma". Ms Taggart suggested increasing their sessions to weekly, but the claimant refused. She also stated that her chiropractic treatments were helping her migraine headaches.

On 03/14/2007, the claimant discussed her physical and emotional pain. Emotional support was provided by the therapist. When she was seen on 03/28/2007, the clamant discussed having back pain. Ms. Taggart stated that she would be leaving the agency and wanted to meet weekly until she left on 04/18/2007. On 04/04/2007, the claimant was noted to have received a new pain medication. She was assigned a new therapist, Joe Cesaro, and was scheduled to meet with him on 04/25/2007.

**Documents Sent for Review and Attending Provider Contact if Indicated:**

| Document Date or ph. call, date and time | Type of Document or Person you spoke with: | Document Prepared by: |
|---|---|---|
| 04/30/2007 a t0930 | Attempted to contact Ms. Taggart | Peter Mosbach, Ph.D. |
| 05/07/2007 at 1030. | Discussed case with Dr. Farber | Peter Mosbach, Ph.D. |
| 04/30/2007 at 1130 | Re-contacted Karen Levinson | Peter Mosbach, Ph.D. |
| 08/25/2004 – 04/23/2007 | Claim notes | N.A. |
| 08/17/2004 – 09/25/2006 | Progress notes and Attending Physician Statement | Lyzette Velazquez, M.D. |
| 10/07/2005 – 04/04/2007 | Progress notes and treatment plan | Linda Taggart, L.M.S.W. |
| 2004 -2006 | MRI reports | N.A. |
| 03/13/2006, 11/26/20206 | Progress notes | Signature illegible |

**Discussion with Attending Provider:**

I attempted to speak with Ms. Taggart on 04/30/2007. I was informed that she had left the agency and was not available. I spoke to the clinic director Karen Levinson. She stated that she would attempt to contact Ms. Taggart and determine if she would speak with me. I later spoke with Ms. Levinson on 04/30/2007 and was informed that Ms. Taggart would not speak with me as she was no longer involved in treating Ms. Testa, and she did not have access to the medical records. I stated that I would be willing to speak with the new therapist, Mr. Cesaro, but it was not known if he had actually seen the clamant. He never called me back.

**Questions and Reviewer's Response:**

**1. Does the information provided support limitations/restrictions from a mental/ nervous condition?**

The information provided does not support any limitations/restrictions from a mental/nervous condition .

**A. If so, what are they, and how long would they be expected to last?**

This question does not apply.

**Assessment/Rationale:**

The claimant is a forty eight year old woman who last worked on 08/04/2004. The provided medical records from the claimant's therapist primarily discussed the claimant's migraine headaches and other pain conditions. The progress notes do not document any significant limitations/restrictions from a mental/nervous condition. Linda Taggart, LMSW completed a Psychiatric Attending Physician's Statement of Disability on 11/17/2006. She diagnosed the claimant with an adjustment disorder with depression and anxiety and dysthymic disorder. The claimant's observed symptoms included depression, obsessional cognitive patterns and anxiety about her inability to function in the future.

Her thought processes were described as logical and coherent. Hallucinations, delusions, suicidal ideation and homicidal ideation were not present. She was oriented. The form stated that the claimant had impairments in attention, concentration and memory. It was also noted that the claimant was capable of performing any tasks of their occupation if migraine conditions were not present. It was also stated that the claimant could return to work if her migraines were controlled.

Even though the claimant was described as having problems in attention and concentration and memory, there was no objective evidence of any cognitive or memory impairments in the progress notes. There was no evidence of a mental status exam being

conducted by Ms. Taggart. The claimant had not received any neuropsychological testing to assess her cognitive functioning. There is also no objective evidence that the claimant's depression and anxiety were severe enough to cause any significant limitations or restrictions. Thus, the information provided does not support any limitations/restrictions from a mental/ nervous condition.

Peter Mosbach, Ph.D.

Peter Mosbach, PhD
Clinical Psychology
MA: 4495

**Advisory Report #2 – Second reviewer – Dr. Farber**

**Clinical History:**

The claimant is a 48 year old payroll supervisor, who according to the limited documentation provided for review, has a history of complicated migraine headaches (1985), anxiety/depression, cervical neck and lumbar radiculopathy, left shoulder rotator cuff tendinosis/impingement (2004), and knee discomfort s/p unclear invasive intervention (1995, 1996).

The claimant's history is significant for migraine headaches (1985) complicated in 2004 by increased frequency and duration and development of additional symptoms (visual aura, photophobia, nausea, vomiting, sleep disruption, concentration and memory impairment, etc). Furthermore, throughout the years she had various subjective complaints (tenderness to neck, low back, knees, and shoulder) and physical examination findings (tenderness with limited range of motion, decreased grip, and non-specific decreased pinprick sensation) suggestive of arthritic cervical and lumbar disease complicated by radiculopathy.

She has been under care of various specialists (neurologist, chiropractic) with extensive diagnostic testing including MRI (08/10/2004) and MRA (09/28/2006) of the brain that revealed a tiny foci of hyperintensity in the subcortical white matter and left lentiform nucleus that was of unknown and questionable significance and no evidence of vasculitis respectively. Cervical MRI (08/20/2004) and NCV/EMG studies (08/17/2004) revealed mild central canal stenosis at C5-6 and C6-7 with disc osteophytes and protrusion contributing to compression of right ventral cord and moderate to severe multilevel foraminal stenosis with specific impingement on left C6 nerve root and radiculopathy was supported by abnormal NCV/EMG studies suggestive of left C6-7 nerve root dysfunction. Left shoulder x-ray (07/31/2006) revealed calcific tendinopathy and osteoarthritic change of the AC joint. There were no knee or lumbar imaging results

made available for review. Furthermore, there was no discussion of any orthopedic evaluation or clear treatment plan regarding any of the musculoskeletal diagnoses.

The notes suggest that her headaches and musculoskeletal complaints were incompletely controlled despite reported participation in PT (no documentation provided) and many adjustments to medications (pain relievers, anti-inflammatories, muscle relaxants, migraine specific agents, antidepressants, etc) and she was eventually referred to psychiatry (10/07/2005) for development of anxiety/depression reportedly complicated by mood swings (11/2004) and subjective inability to perform work related functions. While anxiety/depression may affect pain perception, cognition, and overall functional ability, further discussion was deferred to reviewing psychiatrist and beyond scope of my review.

**Documents Sent for Review and Attending Provider Contact if Indicated:**

| Document Date or ph. call, date and time | Type of Document or Person you spoke with: | Document Prepared by: |
|---|---|---|
| 05/04/2007 at 1630 | Attempted to contact Dr. Velazquez | Dr. Farber |
| 05/07/2007 at 0945 | Attempted to contact Dr. Velazquez | Dr. Farber |
| 05/07/2007 at 1025 | Discussed case with Dr. Mosbach | Dr. Farber |
| 05/07/2007 at 1430 | Attempted to contact Dr. Velazquez | Dr. Farber |
| 05/08/2007 at 0900 | Attempted to contact Dr. Velazquez | Dr. Farber |
| 05/08/2007 at 0930 | Discussed case with Dr. Velazquez | Dr. Farber |

**Discussion with Attending Provider:**

Several attempts were made at various times reflected in the above grid. When I spoke with staff on 05/07/2007, they assured me she would call back and when I did not get a return call I called again in the afternoon and she was gone for the day. The staff told me she would be in again at 0900 on 05/08/2007 and I placed call promptly and spoke to staff. They stated that she has not arrived yet but is due in at any moment. I expressed urgency of timing to staff and that I need to speak with her as soon as she arrives for the day.

The case was discussed with AP today, 05/08/2007 and after extensive discussion, she feels that the claimant's musculoskeletal concerns come and go and that most limiting factor appears to be related to depression affecting headaches and the ability to function. More specifically, she states that the claimant's depression affects her cognition and ability to make decisions despite compliance with various therapeutic regimens. With

regards to musculoskeletal diagnoses, she did not have any physical therapy or orthopedic data to provide for review.

**Questions and Reviewer's Response:**

**1. Do the records support that the claimant continues to be impaired from a physical condition?**

Yes, the records do support that the claimant continues to be impaired from a physical condition.

**A. If so, what are her limitations/restrictions, and how long would they be expected to last?**

Taking all of her comorbidities into account, climbing should be completely restricted and ability to lift, push, pull, and carry weight should be limited up to about 15-20 pounds. Reaching may be limited due to left shoulder tendinopathy, however the specific degree and duration was difficult to determine without PT data or clear complete functional assessment examination data for review. Furthermore, frequency of standing and navigating stairs would likely be limited to occasional, however once again, severity of knee and lumbar back disease could not be determined based upon limited objective data provided for review. There was no objective data to support any long-term cognitive dysfunction or inability to sit and perform most fine motor and fingering activities. Taking all of the above restrictions into account, she should be able to complete an eight hour day of at least sedentary to light duty with the above modifications. .

**Assessment/Rationale:**

The claimant is a 48 year old payroll supervisor, who according to the documentation provided for review, has a history of migraine headaches (1985), anxiety/depression, cervical neck and lumbar radiculopathy, left shoulder rotator cuff tendinosis/impingement (2004), and knee discomfort s/p unclear invasive intervention (1995, 1996). Please refer to history section for further details.

Taking all of her comorbidities into account, climbing should be completely restricted given cervical and shoulder disease and ability to lift, push, pull, and carry weight should be limited up to about 15-20pounds. Reaching may be limited due to left shoulder tendinopathy, however specific degree of limitation and duration was difficult to determine without physical therapy data or clear complete functional assessment examination data for review. Furthermore, frequency of standing and navigating stairs would likely be limited to occasional however once again, severity of knee and lumbar back disease could not be determined based upon limited objective data provided for review. There was no objective data to support any long-term cognitive or motor dysfunction due to migraine or inability to sit and perform most fine motor and fingering

activities. Taking all of the above restrictions into account, she should be able to complete an eight hour day of at least sedentary to light duty with the above modifications.

While anxiety/depression may affect pain perception, cognition, and overall functional ability, further discussion was deferred to reviewing psychiatrist and was beyond the scope of my review.

Michael Farber, MD
Board Certified
Internal Medicine
NJ: 25MA06935900

**Consensus Opinion (Written by Lead Reviewer): Dr. Mosbach**

Dr. Farber and I agreed that the claimant did not manifest any significant functional limitations and restrictions from a psychological perspective. He stated that the claimant was capable of sedentary to light duty work. I found no evidence of any limitations or restrictions due to a mental or nervous condition. We were in agreement.

All medical records provided by The Hartford were reviewed. Yes ☒ No ☐
I attest that my completion of this review does not constitute a conflict of interest. Yes ☒ No ☐

Peter Mosbach, MD
Michael Farber M.D.